## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/08/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING		(X3) DATE SURVEY COMPLETED	
		185362	B. WING		02/0	C 01/2011
NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY		- 1	TREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET NEW CASTLE, KY 40050			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X6) COMPLETION DATE
	O1/31/11 through 02 KY15199 which was cited at 483.13 Resi of a "D".  483.13(c) DEVELOI ABUSE/NEGLECT,  The facility must devipolicles and procedi mistreatment, negle and misappropriatio  This REQUIREMEN by: Based on interview a determined the facility policies on abuse in three (3) sampled repotential abuse while completed as evider suspended an employer ball abuse during  The findings include: Review of the facility 10/1999, during abus will be protected from reassigning the accurd not involve reside suspended without peen reviewed by the employee be reassigduties, such assignment.	rey was conducted on 1/01/11 for the complaint is substantiated and deficiency ident Behavior, F226 at a S/S P/IMPLMENT ETC POLICIES  relop and implement written ures that prohibit ot, and abuse of residents in of resident property.  T is not met as evidenced and record review, it was ty failed to implement their order to protect one (1) of sidents (Resident #1) from an investigation was used by the facility's failure to be with an allegation of the investigations, residents in harm by immediately sed employee to duties that	F 226	statement of deficiencies. However, in an effethe care furnished to our residents, we have at some of our existing policies and protocols. Vacknowledge that federal and state regulations require a plan of correction, and we are therefore submitting this plan.	forth in the ort to enhance igmented Ve is presented in the ort to enhance igmented Ve is presented in the important in the i	2-14-2011
لــــ		VOMOBILED DEPOSOSNITATIVES OF NA		T(T) C		VAL DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient prefection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: CDKP11

FEB 1 6 2011

Facility ID: 100435

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				WING		C 02/01/2011	
	PROVIDER OR SUPPLIER	ER, NEW CASTLE, KENTUCKY		TREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET NEW CASTLE, KY 40050			
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	Review of the facility allegation that Emple to Resident #1 reve investigation on 08/employee Certified it the complaint involvement was completed on 0 Review of the facility CNA #1 worked on the investigation: 08/10/Interview with Resider questions regarding Review of the clinical revealed the resident questions regarding Review of the clinical revealed the resident questions regarding Review of the clinical revealed the resident pata Set assessment 11/14/10. The resident memory deficits and required extensive and incontinent of bowel also refused care.  Interview with Social 8:40am revealed CN verbally abusive to Refacility's policy was to abuse during an inverse meant a suspension interview with Licens on 02/01/11 at 8:50am and the decision of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility normalleged with abuse possible investigation of the stated the facility of the stated the facili	y's investigation of the oyee #1 was verbally abusive aled the facility initiated the 10/10 when a former Nurse Aide (CNA) #2 called in ing CNA #1. The investigation 8/13/10.  y's staffing schedule revealed hree (3) days during the 10, 08/11/10 and 08/12/10.  ent #1 on 02/01/11 at 8:10am it was unable to answer any the incident.  If record for Resident #1 thad an annual Minimum in completed by the facility on in thad short and long term was nonambulatory and saistance. The resident was and bladder. The resident  Services on 02/01/10 at A #1 denied she had been esident #1. She stated the oprotect residents from stigation and normally this	F 226	Assurance committee for three (3) months committee will determine need for committee.  5. The Administrator is responsible for committee guidance of the Director of Operations.	uation. mpliance under	3-15-2011	

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Event ID: CDKP11

Facility ID: 100435

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		The state of the s	A. BUILI	DING	COMPI	COMPLETED  C 02/01/2011	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	V SHOULD BE	(X6) COMPLETION DATE	
F 226	revealed she did no She stated she was	#1 on 02/01/11 at 9:45am at verbally abuse Resident #1. a not suspended during the by's investigation for verbal	F 22				
		-					

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